Guam Behavioral Health and Wellness Center		
TITLE: Quality Improvement Program	**POLICY NO.:** **AD- QM- 1**	Page 1 of 6
RESPONSIBILITY: Quality Management		
APPROVED BY: Rey M. Vega REY M. VEGA, DIRECTOR	**EFFECTIVE:** 3/27/17 **LAST REVIEWED/REVISED:**	

PURPOSE:

A. To provide a Quality Performance Improvement (QPI) program for the Guam Behavioral Health and Wellness Center (GBHWC) that supports its vision, mission, and organizational priorities.

POLICY STATEMENT:

A. The leadership and management of GBHWC support an environment that encourages the identification of improvement opportunities from all sources throughout the organization and the provision of care and services that are reflective of the organization's mission and vision (*see Mission, Vision and Core Value Policy AD-23).*

B. GBHWC shall have a quality improvement plan that provides a systematic, coordinated, continuous data driven approach to improving performance focusing on processes and mechanisms of services that are provided in a safe, effective, consumer centered, timely, equitable and recovery oriented fashion.

RESPONSIBLITIES

A. Leadership / Director
   a. It shall support and guide implementation of quality improvement activities at GBHWC.
   b. It shall review, evaluate and approve the Quality Improvement Plan annually.
   c. Shall review reported QI data of all clinical programs, health and safety, risk management as well as business function data such as but not limited to financial reports, human resources and technology report.
   d. Shall approve and prioritize performance improvement initiatives, system and process redesign or change as recommended by QAPI Committee to improve quality of care and consumer satisfaction.
   e. Provide oversight and leadership for all activities relative to GBHWC's Performance Improvement Plan.

A. The QPI Committee
   The Quality Performance Improvement Committee (QPIC) shall be created to develop the Quality Improvement Plan and provide ongoing operational leadership of continuous quality improvement activities.
   a. It shall be chaired by the Director or designee
   b. The membership of the QI Committee shall be as follows
      i. Medical Director
      ii. CARF Compliance Officer
      iii. Quality Improvement Coordinator (QIC)
      iv. Risk Manager Officer or designee
      v. Nursing Administrator or designee

vi. Program Head/Supervisors (Adult Outpatient Mental Health, Child and Adolescent Services, Residential Treatment Program, Drug & Alcohol, Healing Hearts, Prevention & Training) or designee
vii. Health and Safety/Infection Control Supervisor
viii. Clinical Administrator

c. It shall meet at least monthly to report and review quarterly data gathered from each department.

d. It shall review the Quality Improvement Plan annually and establish measurable objectives based upon priorities identified through the use of establish criteria for improving the quality and safety of clinical services..

e. It shall support improved consumer outcomes by identifying education and training opportunities for personnel and targeting areas in which improvement is needed by reviewing results, performance indicators, consumer feedback.

f. The responsibilities of the committee shall include but not limited to;
   i. Provide oversight and direction to the Program Heads on their Performance Improvement measures.
   ii. Prioritize measures that include high risk and problem prone areas identified throughout the organization, which are trended and analyzed by departments.
      1. The Program Heads or Supervisor shall oversee his/her department's PI measures.
      2. Each department is considered a working team, wherein problems are identified, and an efficient process is strategized and monitored for sustainability.

   iii. Periodically assess information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.

   iv. Establish, as needed, a Performance Improvement Action Team (PIAT) an interdepartmental membership team who are the main stakeholders to the planned improvement or process of change.
      1. Members of the PIAT shall be appointed by the Department head or supervisor.
      2. The Performance Improvement Action Team shall report to the QPI committee on its action status as necessary or when ask to report.

   v. Formally adopting a specific approach to Continuous Quality Improvement e.g. Plan-Do-Check-Act (PDCA), and Lean Enterprise method as deemed appropriate.

B. <u>Quality Improvement Coordinator</u>
The Quality Improvement Coordinator (QIC) shall guide the construction of performance measures, coordinate and monitor the performance indicator and the implementation of

the quality improvement programs relating to patient care and support services. The responsibilities shall include but not limited to;

a. Develops and monitor the implementation of quality improvement program.
b. Coordinates program activities with the clinical staff, program or departmental heads.
c. Supervises the performance improvement working team of a program or employees who lead or facilitate quality improvement activities.
d. Provide project management, data analysis and measurement of outcomes, document and report the results and accomplishments of quality improvement initiatives to the QPI committee.
e. Evaluates the effectiveness of agency/departmental quality improvement programs and makes recommendations to identified problems.
f. Coordinates and participates in the quality improvement monitoring activities through chart review, gathering, and collecting data.
g. Gathers compiles and analyzes data from different program and prepare report for presentation to the QAPI committee for review and approval.
h. Conducts educational programs related to quality improvement methodologies and activities as required.
i. Monitors departmental compliance to established quality improvement policies and procedures and reporting calendar.
j. Maintains data records and prepare quarterly and annual trending reports.

The QPI Program

A. The QPI Program shall objectively and systematically monitor and evaluate the quality of care, the services provided to the consumer by assessing care delivery, its effectiveness and efficiency of service, consumer safety, and customer satisfaction.

a. Performance Measures, Data Collection and Analysis
    i. Data shall be collected on key systems, processes and clinical outcomes to monitor effectiveness, efficiency of service, access to care and consumer satisfaction in accordance with Commission on Accreditation for Rehabilitative Facilities (CARF) standards.

    ii. Data collected shall be trended over time to display any variations, improvements and benchmarking with international standard.

    iii. Data collected shall be transformed into performance information and knowledge when analysis is undertaken.
        1. The data shall be processed and synthesized so that GBHWC leadership can make informed assumptions and generalizations about what has happened, why this might vary from what was expected, and what corrective action might be required.

    iv. Performance Measure shall be evaluated and analyzed annually by the Quality Improvement Coordinator in preparation for the beginning of the new calendar year's PI plan creation.

b. Data Collection

Data collection shall be done on a monthly basis. The methods in which data will be collected shall be determined by the departments and stated in Performance Improvement plans, with guidance from QI Coordinator and the QPI Committee.

i. The organization shall take steps to ensure that data are reliable; by training new and existing personnel on recording each data element they are responsible for collecting.
ii. Indicators are explained and periodically reviewed.
    1. Indicators are defined with detail, data elements and the type of numerical value to be used to express the indicator e.g. percentage, rate, number of occurrence etc.
    2. Data collection shall be described; how the data will be collected as well as method and frequency of collection, and who will collect the data.
iii. The organization shall choose indicators and data elements that measure what it intends to measure.
iv. The organization shall take steps to ensure that data used for decision making are complete. Database is checked for completeness of records before final analyses are run and decisions made.

c. Guidance for continuing or discontinuing monitoring
    i. Standards based measures or mandated indicators from regulatory bodies (e.g. CARF) shall continually be monitored, reflected on one's PI plan, trended, analyzed and reported.

    ii. Monitoring activities can be decreased or eliminated for other PI indicators that sustained 95% compliance for a period of 6 consecutive months.
        1. Reporting of this data to QPIC can be discontinued after informing the QPIC as a courtesy; reporting will ensue as needed when significant concerns surface or negative trends arise.
        2. Monitoring activities (trending, analysis) can be decreased in frequency from monthly to quarterly and reduced to random spot audits. If compliance is sustained, the measure or indicator may be dropped from monitoring activities and the PI plan must be updated accordingly.

d. Priorities for Monitoring- Standards Related Indicators
    i. In accordance with CARF performance measurement and management standard, the following indicators shall be monitored and analyzed.
        1. Services delivery performance indicators for each program area such as effectiveness of service, efficiency of service, service access satisfaction and other feedback from persons served and stakeholder.
        2. The organization collects data about the consumer at the beginning of services, appropriate intervals during services, at the end of services and points in time following the services.
    ii. The data collected shall address the needs of the persons served, the needs of the other stakeholders and the business needs of the organization.

1. The data collected by the organization shall also include but not limited to;
    a. Financial information,
    b. accessibility status reports,
    c. risk management,
    d. human resources activities,
    e. technology,
    f. health and safety reports,
    g. satisfaction surveys

iii. The data collected are used to set written business function and written service delivery, objectives, performance indicators and performance targets.

e. Reports

i. Quarterly narrative reports:
Narrative reports from department will primarily focus on the PI indicator that did not meet goals. These reports shall be submitted to the QI Coordinator the month after quarter- end date during the QPI Committee meeting. (*See attachment I for performance improvement report).*

ii. Trending Sheets
Trending sheets reflect the performance of all measures/indicators being monitored by departments (based on their PI Plans) over the course of the calendar year. This must be submitted by the Quality Improvement Coordinator annually to the appropriate division head and to PIC. The format for trending sheets shall be based on *Attachment II Performance Improvement Trending Sheet.*

iii. Action Plans
Action Plans should accompany the trending sheets and or quarterly narrative reports when measures/Indicators do not meet expected target goals. The format of action plans may vary, but the following components must be included (*See Attachment III).*

1. WHAT – describe the improvement actions undertaken
2. WHEN – indicate the dates of when the actions will be completed
3. WHO – identify those responsible for completing the actions

f. Performance Improvement Model
An interdisciplinary, continuous, performance improvement approach is recognized across GBHWC organization continuum of care and service areas utilizing **FOCUS PDSA model.**

i. **FOCUS** is defined as:
1. **FIND** a process that needs improvement
2. **ORGANIZE** a team that knows the process
3. **CLARIFY** the current knowledge of the process
4. **UNDERSTAND** the process and learn the causes of variation
5. **SELECT** a strategy for continued improvement; start the PDCA cycle

ii. **PDSA** cycle is defined as:
   1. **PLAN -** is based on the result of data collection or the assessment process. The plan should include how the process will be improved and what will be measured to evaluate the effectiveness of the proposed process change.
   2. **DO -** includes the implementation of the process changes. These changes may be tested before changing policies and procedures or conducting extensive education.
   3. **STUDY-** evaluates the effect of the action taken at a given point in time
   4. **ACT-** is to maintain and hold the gain and to continue to improve and implement the process

g. Performance Improvement Plans
Performance Improvement Plan is a list of all measures/indicators that department choose to monitor over the course of the calendar year. Format for PI plan shall follow the Performance Plan template (*see Attachment IV)*
   i. It shall undergo review and approval by the Performance Improvement Committee
   ii. Evaluated PI plans and newly created PI plan shall be submitted to the appropriate Division Heads, prior to year end, at a date specified by PIC,
   iii. All PI Plans shall be collected by the Quality Improvement Coordinator

C. Communication Information Pathway
   a. QAPI activities are communicated through the established QAPI Information Pathway (*See attachment V Data Reporting Flow Chart)*

DEFINITIONS:

1. Performance Measure: The process of regularly assessing the results produced by the program. It involves identifying processes, systems and outcomes that are integral to the performance delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis.
2. Performance Indicator: A quantitative tool that provides information about the performance of a clinic's or program's process, services, functions or outcomes.

REFERENCES:

CARF. (2016). *Behavioral Health Standards Manual.* Tucson, Arizona: CARF International.
White, S. V. (2012).
Quality and Performance Improvement Q Solutions. Glendale Illinois: National Association for Healthcare Quality.

ATTACHMENTS:

I. Performance Improvement Quarterly Report
II. Performance Improvement Trending Sheet
III. Performance Improvement Action Plan
IV. Performance Improvement Plan Template
V. Data Reporting Flow Chart
VI. GBHWC Performance Improvement Plan

Guam Behavioral Health and Wellness Center
Quality Improvement Plan
Performance Indicator for 2018

Mission and Vision

Guam Behavioral Health and Wellness Center is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. It is task with providing a comprehensive behavioral health services for the people of Guam. Its mission is to provide a culturally respectful quality behavioral health services that support and strengthen the wellbeing of persons served, their families and the community in a safe environment.

GBHWC envision a healthy Island committed to promoting the behavioral health and wellbeing of our community.

Business Functions					
Objective	**Indicator/Definition**	**Time of Measure**	**Applied to**	**Data Source Responsibility**	**Target**
To increase overall satisfaction of staff and other stakeholder	Staff Input satisfaction	Semi Annual	Personnel other stakeholder	Survey form	85% of staff will be satisfied with GBHWC
To maintain stability and continuity of personnel	**Turnover rate of employees.** Numerator: Total # of staff who resigned at the end of measurement period. Denominator: Ave # of employees during the measurement period.	Annual	Personnel	Human Resources. EEO Exit interview	Staff turnover < 5%
To maintain stability and continuity of personnel	**Retention Rate** Numerator: Total # of staff that remained employed during the measurement period/ Denominator: # of employees at start of measurement period)	Annual	Personnel	Human Resources EEO Exit Interview	

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Adult Out Patient Mental Health					
Objective	**Indicator/Definition**	**Time of Measure**	**Applied To**	**Data Source Responsibility**	**Target**
Input from Consumers/Satisfaction					
Consumers will report satisfaction in accessing a service, and provision of service. Consumer will report that they are treated with respect	% of Consumers who indicate overall satisfaction of the services they received % of consumers who indicated that they were treated with respect.	Bi annual	Consumers	Survey form	85%
Access to Service Measure					
To decrease # of days to enter a program To decrease the time taken from screening to intake of non-emergency consumers. To reduce the no show rate of consumers	% of consumers will have complete intake assessments within 10 working days from screening. % of Lead Providers contacted consumers within 48 hours of screening. % of consumer who did not show up for their scheduled appointment and did not call to reschedule within 24 hours of the appointment. **Numerator:** Total # of consumers who didn't show up for their appointment. **Denominator:** Total scheduled appointments	Monthly	Consumers Consumers	Source: AWARDS Intake Module Responsibility: Program Appointment schedule	85% of consumer will have complete assessments within in 10 working days
Efficiency of Service Measure					
To improve the compliance of writing interpretive summaries and initial treatment plan.	% of Interpretive Summaries & initial treatment plan done in a timely manner completed within 2 working days after completion of intake	Monthly	Consumer	Source: Med Clinic Schedule Group Therapy schedule	85%

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2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Effectiveness Domain					
Consumers will improve in 90 days after receiving treatment. To increase the # consumers who met their goal upon discharge.	% of consumers with depressive disorder will improve in their PHQ score after 90 days of receiving treatment. % of consumer who met their goal upon discharge	Quarterly Monthly	Consumers Consumers	EBHR	75%
Influencing factors or consideration(Demographics)					
Barriers to Successful outcomes					
Severity Challenges					

Child and Adolescent Services Division						
Objective	**Indicator/Definition**	**Time measured**	**Applied To**	**Data Source**	**Obtained By**	**Target**
Consumer Input/Satisfaction						
Consumers will report satisfaction in accessing a service, and provision of service. Consumer will report that they are treated with respect	% of Consumers who will indicate overall satisfaction of the services they received % of consumers who indicated that they were treated with respect.	Bi annual	Consumers	Survey form	Jesse Libby	85% will state overall satisfaction 85% will indicate they were treated with respect

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Access to Service Domain						
To ensure that consumers are accessing services in a timely manner. To reduce and improve the no show rates of the consumers	% of consumers will be staff and have first services provided within 10 working days of intake - average # of days from screening/intake to first contact % of consumer who did not show up for their scheduled appointment and did not call to reschedule within 24 hours of the appointment.	Monthly Monthly	Consumers	Source: EBHR Responsibility: CASD Appointment schedule	Jesse Libby	85% of consumers will be assigned to staff within 10 days of intake
Efficiency Domain						
To improve the compliance of interpretive summary and initial treatment plan.	% of interpretive summaries and initial treatment plan done within 72 hours of intake.	Monthly	Staff	EBHR	QIC	85%
Effectiveness Domain						
consumers will improve in their CANs score	% of consumers who improved in their CANS assessment after 90 days of service, and 120 days of service.	Quarterly.	Consumer	EBHR	Jesse Libby	75%

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Crisis Stabilization: Adult/Child Inpatient Unit						
Objective	**Indicator/ Definition**	**Time Measured**	**Applied to**	**Data Source**	**Obtained by**	**Target**
Consumer Input Satisfaction						
Consumers will report satisfaction in accessing a service, and provision of service. Consumer will report that they are treated with respect	% of Consumers who will indicate overall satisfaction of the services they received % of consumers who indicated that they were treated with respect.	Bi annual	Consumers	Survey form		85% will be satisfied with the service 85% will indicate they were treated with respect
Efficiency Domain						
To improve the compliance of writing an initial treatment plan in a timely manner.	% of admitted consumers shall have a completed initial treatment plan within 24 hours of admission.	Monthly	Consumers	Source: EBHR Responsibility:		90%
Effectiveness Domain						
To reduced the incidence of readmission or relapse To maximized and improved the length of stay of consumers	% of consumers that were readmitted within 15 and 30 days of discharge Average length of stay. % of consumers who stayed in the unit within 7 days.	Monthly	Consumers	Source: EBHR Responsibility		<5% of clients will have a readmission

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2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Crisis Intervention Unit : Healing Hearts						
Objective	**Indicator/Definition**	**Time Measured**	**Applied to**	**Data Source**	**Obtained by**	**Target**
Consumer Input/Satisfaction						
Consumers will report satisfaction in accessing a service, and provision of service. Consumer will report that they are treated with respect	% of Consumers who will indicate overall satisfaction of the services they received % of consumers who indicated that they were treated with respect.	Bi annual	Consumers	Survey form		85% will be satisfied with the service 85% will indicate they were treated with respect
Access Domain						
To decrease the number of days to process an intake after first contact. To reduce the no show rate of consumers	% of non-acute consumers will receive an intake within 5 business days of first contact. Average wait time. % of consumer who did not show up for their scheduled appointment and did not call to reschedule within 24 hours of the appointment.	Monthly	Staff	Source: EBHR,HCC Log book Responsibility:		85 % of consumers will be process within 5 working days
Efficiency Domain						
To maximize and improve the length of stay of consumers To improve compliance of Interpretive summary and initial treatment plan in a	% of consumers will complete case management services within 10 weeks - Average LOS % of Interpretive Summaries & initial treatment plan done in a timely manner completed within	Monthly Monthly	Staff Staff	Source: EBHR. HHCC log Responsibility:		90% 85%

GUAM BEHAVIORAL HEALTH AND WELLNESS CENTER
2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

timely manner	2 working days after completion of intake					
Effectiveness of Service						
To improve the completion rates of program services	% of consumers who successfully completed the program and met their goal.	Monthly	consumers	Source: EBHR, HHC log Responsibility:		95%

Crisis Intervention: Drug & Alcohol Program						
Objective	**Indicator/ Definition**	**Time Measure**	**Applied to**	**Data Source**	**Obtained By**	**Target**
Input from Consumer						
Consumers will report satisfaction in accessing a service, and provision of service. Consumer will report that they are treated with respect	% of Consumers who will indicate overall satisfaction of the services they received % of consumers who indicated that they were treated with respect	Bi annual		Survey form	Clinical Program	85% will be satisfied with the service 85% will indicate they were treated with respect
Access Domain						
To decrease the number of days to process an intake after first contact.	% of consumers will receive treatment within 10 working days of first contact	Monthly	Consumers	Source: EBHR, Log book Responsibility:	Clinical Program	85% of
Efficiency Domain						
To improve compliance of treatment plan	% of consumers who received treatment will have a complete treatment plan within 10 working days.	Monthly	Staff	Source: EBHR. D&A log Responsibility:	Clinical Program	85 % of consumers will have treatment plan within 10 days

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2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Effectiveness Domain						
To reduced incidence of relapse and maintain abstinence from primary drug of choice	% of consumers who maintained their abstinence from primary drug of choice.	Monthly	Consumers	Source: D&A Log	Clinical Program	85% will report abstinence

Residential Recovery Program						
Objective	**Indicator/ Definition**	**Time measure**	**Applied To**	**Data Source**	**Obtained by**	**Target**
Input from consumer						
Consumers will report satisfaction in accessing a service, and provision of service. Consumer will report that they are treated with respect	% of Consumers who will indicate overall satisfaction of the services they received % of consumers who indicated that they were treated with respect	Bi annual		Survey form		85% will be satisfied with the service 85% will indicate they were treated with respect
Access Domain						
To reduce the number of days of processing a referral and acceptance to a program Acceptance Rate	% of consumers referred to the program will be given disposition within 5 working days. Acceptance Rate	quarterly	Consumers	Source: EBHR, Log book	Program	100 % 100%
Efficiency Domain						
To improved compliance of Treatment plan review on a timely manner	% of staff will be able to complete their treatment plan review in a timely manner. Occupancy Rate	Monthly	Staff	Source: EBHR. Responsibility:	Program	100% of treatment plan will be reviewed

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2018 QUALITY IMPROVEMENT PLAN
Performance Indicator for 2018

Effectiveness Domain						
To reduce the number of incidence requiring AIU admission	% of Relapse requiring AIU admission	Monthly	Consumer	Source: Program log book. EBHR		<5%

Quality Improvement Committee:

_____
GBHWC Director: Rey M. Vega

Date Approved: _____
Date Reviewed/Revised:

_____
Chairperson: Cydsel Victoria Toledo- Quality Improvement Coordinator

Members:
Medical Director: Dr Ariel Ismael _____
Psychologist: Dr. Mary Fegurgur _____
Acting Nurse Supervisor: Jeremy Lloyd RN _____
Acting Clinical Administrator: Reina Sanchez _____
Administrator CASD: Annie Unpingco _____
Prevention & Training Branch Supervisor: Linda Flynn _____
Residential Recovery Program Manager: Shermalin Pineda _____
Acting Adult Counseling Supervisor: Frances Munoz _____
Acting CSS Supervisor: Marilyn Miral SW III _____
Drug and Alcohol Program Supervisor: Athena Duenas _____
Healing Hearts Program Manager: Maria Teresa Aguon _____
Health and Safety Officer: Alfred Garrido _____

GBHWC 2018 Indicators

Adult Outpatient Program	Target	Result
Consumer will have complete assessment within 10 working days of screening	90%	
No Show Rates at Medication Clinic and Therapy Groups	< 30 %	
Interpretive summaries and Initial Tx. plan compliance in a timely manner	90%	
Service Utilization: Total Consumers Seen, Walk in Visits, Crisis		
% Discharge consumers who met their goal	80%	
% Consumers who drop out or no engagement	< 20 %	
% Consumers in adult Safe Seeking Grp. who improve in their PHQ after completion of program.		
Satisfaction Survey		
Crisis Stabilization Unit	**Target**	**Result**
Crisis hotline calls		
Adult Inpatient Unit admission		
Court Ordered Admission		
Treatment Plan Compliance		
15 day readmission rate	< 5%	
16-30 day readmission rate	< 5%	
Length of Stay in Crisis stabilization	< 5 days	
Seclusion and Restraint log		
Residential Recovery Program	**Target**	**Result**
Acceptance Rate: Total consumers referred to the program, consumers accepted, wait list	100%	
Occupancy Rate	100%	
% of Consumers who moved in the home within 7 days of admission to the program	100%	
Treatment Plan Monthly Review Compliance	90%	
Incidence of relapse requiring AIU admission	<5%	
% of consumers in the residential homes who improved in their IADL assessments for the quarter		
Discharges to higher independence, Total consumer integrated to community		
Satisfaction survey		
Child Adolescent Services	**Target**	**Result**
Satisfaction Survey		
Service Utilization: Total consumers admitted, Discharge		
% of consumers will be staffed and have first services provided within 10 working days of intake		
No show rate		
Interpretive summaries and Initial Tx. plan compliance in a timely manner		
% of consumers who improved in their CANS assessment after 90 days of service, and 180 days of service.		
Healing Hearts	**Target**	**Result**
Satisfaction Survey		
Service Utilization: Admissions, Discharge		
% of non-acute consumers will receive an intake within 5 business days of first contact		
Interpretive summaries and Initial Tx. plan compliance in a timely manner		
No show rate		
% of consumers will complete case management services within 10 weeks		
% of consumers who successfully completed the program and met their goal		

GBHWC 2018 Indicators

Drug & Alcohol Program Intensive and Outpt. program	Target	Result
Satisfaction Survey		
No show rate		
Service Utilization: Admissions, Discharge		
% of consumers will receive treatment within 10 working days of first contact		
% of consumers who received treatment will have a complete treatment plan within 10 working days.		
% of consumers who maintained their abstinence from alcohol 30, 60, & 90 days ff. up		
Business Function	**Target**	**Result**
Employee Satisfaction Survey		
Turnover rate of employees		
Retention Rate of Employees		
Number of Vacancies		
Key positions filled at all times.		
Health and Safety	**Target**	**Result**
Critical Incidents: rate of consumer and staff injuries, workers comp		
Safety Audit inspection & building grounds inspection will yield no more than two repeat findings per audit		
Training	**Target**	**Result**
% of residential home staff currently CPR certified		
% of direct care staff currently PCM certified		